STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455714	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm Northwest	17600 Cali Dr Houston, TX 77090

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who were unable to carry out activities of daily living received necessary services to maintain grooming and personal hygiene for 2 out of 8 residents (Resident #3 and Resident #4) reviewed for ADLs. The facility failed to check and/or change Resident #3 for more than six hours on 4/9/26 and for more than seven hours on 4/10/26.The facility failed to check and/or change Resident #4 for more than five hours on 4/9/26. This failure could place residents at risk of skin breakdown, infection, and reduced feelings of self-worth. Findings included: 1.Record review of Resident #3's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of spinal stenosis of lumbar region (narrowing of the spinal canal in the lower back), type 2 diabetes (high blood sugar), heart failure (heart is not pumping effectively), extrapyramidal and movement disorder (uncontrolled movements), need for assistance with personal care, severe obesity, and TIA and CVA (mini stroke and stroke). Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting and required a Hoyer lift to get out of bed to wheelchair. Resident #3 was always incontinent of bowel and bladder. Further review revealed to the assessment she was at risk of developing pressure ulcers. Record review of Resident #3's Care Plan dated 9/26/25 revealed the following focus areas: *Urinary Incontinence: Resident #3 had bladder incontinence. The goal was to have no alterations in skin integrity related to incontinence or brief use through the review date. The interventions included performing routine rounding to include incontinence care and brief changes.*Bowel Incontinence: Resident #3 had bowel incontinence. The goal was to no alterations in skin integrity related to incontinence or brief use through the review date. The interventions included performing routine rounding to include incontinence care and brief changes.*Pressure Wounds: Resident #3 was at risk for alteration in skin integrity and pressure ulcer formation. The goal was to be free from alteration in skin integrity/formation of pressure wounds over 90 days. Interventions included assisting the resident with incontinent care and assisting her for toileting as indicated. Record review of Resident #3's Physician Orders revealed an order for Furosemide (increases urination) Oral Tablet 20mg 1 PO QD from MD J ordered on 3/24/26. In an interview on 4/9/26 at 9:53am, LVN J said they changed residents Q2hr and PRN. She said even if the resident was sleeping they would check to see if the resident needed to be changed. In an interview and observation on 4/9/26 at 9:58am, Resident #3 was observed on her back in bed. She said the staff did not change her as often as they should. She said she had not been changed since 4:30am that morning. She said she was about to push the call light to ask to be changed because she was currently soiled with urine, and then she pushed the call light. In an interview and observation on 4/9/26 at 12:00pm, Resident #3 was observed on her back in bed. She said she still had not been changed yet and was soiled with urine. She said staff came in and turned off the call light and said they would get an aide to come change her. In an interview on 4/9/26 at 12:34pm, Med Aide L said they rounded Q2hr and PRN. She said if the resident was sleeping, they still would check to see if the resident needed to be changed. She said she did not change residents (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because she passed meds, but if she really needed to help she would. In an interview and observation on 4/9/26 at 4:09pm, Resident #3 was in her wheelchair. She said she had finally been changed, but she did not remember when it was. In an observation and interview on 4/10/26 at 9:15am, Resident #3 was on her back in bed. She said she was last checked/changed at 4:30am. She said no one had asked her or checked to see if she needed to be changed since then. She pushed her call light at 9:17am to be changed because she was soiled with urine. In an observation and interview on 4/10/26 at 9:23am, Resident #3's call light was off. Resident #3 said someone came in and turned her call light off and said they would tell the CNA to come change her. In an observation and interview on 4/10/26 at 10:32am, Resident #3 was lying on her back in bed. Resident #3 said she still had not been changed yet, was soiled with urine, and no one had come in. In an interview on 4/10/26 at 10:34am, CNA G said she was taking care of Resident #3 and she had the front of Resident #3's hall and the front of the 100 hall. She said the 100 hall was where the trach and vent residents were, so the hall was very heavy. She said she was on her way to Resident #3's room to help her. In an interview and observation on 4/10/26 at 12:10pm, Resident #3 was sitting up in bed eating lunch. Resident #3 said she had just been changed a few minutes ago due to being soiled with urine, from when she had been waiting from the morning. Record review on 4/10/26 of Resident #3 Bladder Elimination Task revealed the following: 4/9/26: She was changed at 1:41am and 5:51pm by unknown staff4/10/26: She was changed at 1:06am by unknown staff 2. Record review of Resident #4's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis (paralysis and weakness) after a stroke, elevation of liver enzymes, type 2 diabetes (high blood sugar), high blood pressure, and lack of coordination. Record review of Resident #4's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 0 out of 15, which indicated severely impaired cognition. Resident #4 had an impairment on one side of both her upper and lower extremities and used a wheelchair for mobility. She was substantial/max assistance (helper does more than half the effort) with toileting. According to the assessment the resident was frequently incontinent of bowel and bladder and was at risk for pressure ulcers. Record review of Resident #4's Care Plan dated 11/27/25 revealed the following focus areas: of*Risk for Pressure Wounds: Resident #4 was at risk for alteration in skin integrity and pressure ulcer formation. The goal was to be free from alteration in skin integrity/formation of pressure wounds over the next 90 days. The interventions included assisting the resident with toileting and assisting the resident with incontinent care as indicated.*Urinary Incontinence: Resident #4 had bladder incontinence related to functional impairment. The goal was to have no alterations in skin integrity related to incontinence or brief use through the review date. The interventions included performing routine rounding to include incontinence care and brief changes and remind and assist the resident to use the toilet regularly as indicated/able. *Bowel Incontinence: Resident #4 had bowel incontinence related to functional impairment. Resident #4 was to have no alterations in skin integrity related to incontinence or brief use through the review date. The interventions included performing routine rounding to include incontinence care and brief changes and remind and assist the resident to use the toilet regularly as indicated/able. **ADL Self Care Deficits: Resident #3 had ADL self-care deficits and was at risk for further decline in ADL functioning. The goal was for the resident to be clean and have dignity maintained. The interventions included providing extensive assistance of 1 support persons for toileting/incontinence care. Record review of Resident #4's Physician Orders revealed an order for Hydrochlorothiazide (increases urination) Oral Tablet 12.5mg 1 PO QD from MD J ordered on 11/29/25. In an interview on 4/9/26 at 12:55pm, Resident #4 said she would not see an aide for four or more hours at a time, routinely. She said she routinely had to wait two and a half hours to be changed, when she was already soiled with urine and feces. Resident #4 said staff came in and turned off the call light but never told the aide she needed to be cleaned. She said today she has not been checked/changed or even been asked since 8:30am. In an interview on 4/9/26 at 1:15pm, CNA S said she checked Resident #4 and changed her roommate before lunch, which was around noon. In an (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 4/9/26 at 1:20pm, Resident #4 said CNA S changed her roommate but did not check her or ask her anything Resident #4 said she was currently soiled with urine. Record review on 4/10/26 of Resident #4's Bladder Elimination Task revealed the following: 4/9/26: She was changed at 8:25am, 4:25pm, and 11:59pm by unknown staff4/10/26: She was changed at 6:53am by unknown staff Record Review of the March 2026 Patient Complaint/Grievance Tracking Log revealed Resident #4 made a complaint about ADLs on 3/4/26. In an interview on 4/10/26 at 9:27am, the ADM said she was the Interim ADM and had been there since 2/27/26. She said she rounded on every resident, every morning and afternoon/evening. She said they also had Ambassador Rounds where leadership rounded on residents. The ADM said since she rounded on every resident it forced leadership to be accountable for Ambassador Rounds because she would find out if they did not perform their rounds. She said when she rounded she did not get any complaints from resident about not being changed. In an interview on 4/10/26 at 2:09pm, the ADM said ultimately the DON oversaw staff to ensure they were changing residents, and the DON performed care huddles with staff to keep reminding them of any issues/concerns. The ADM said if there was a concern found during leadership rounds, they would in-service the staff then. She said she has also called night shift staff if there was an issue/concern with them. Record review of the facility's policy and procedure on Activities of Daily Living (ADLs) - Highest Level of Functioning (revised 1/2026) read in part: It is the policy of this facility to support each resident in maintaining or improving their highest practicable level of functioning related to Activities of Daily Living (ADLs), based on the resident's assessed needs, preferences, goals, and clinical condition. The facility promotes resident independence to the greatest extent possible while providing necessary assistance, supervision, and interventions when residents are unable to safely perform ADLs independently. Activities of Daily Living (ADLs) include personal care tasks such as bathing, dressing, grooming, oral hygiene, eating, transferring, bed mobility, toileting, and communication.Care will be delivered in a manner that supports resident dignity, choice, and autonomy and avoids creating unnecessary dependence.Additional nursing or functional support interventions may be considered based on the resident's condition, response to care, and goals, but are not required for all residents.Direct care staff, including Certified Nursing Assistants (CNAs), provide routine care.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure that residents received care, consistent with professional standards of care to prevent development of pressure ulcers for 3 of 8 (Resident #2. Resident #1, and Resident #3) reviewed for pressure ulcers. The facility failed to turn/re-position Resident #2 every 2hrs and PRN on 4/9/26 and 4/10/26, to help heal his severe sacrum and L thigh pressure ulcers.The facility failed to turn/reposition Resident #1 every 2hrs and PRN on 4/9/26 and 4/10/26, causing the resident to develop redness to her tailbone.The facility failed to turn/reposition Resident #3 every 2hrs and PRN on 4/9/26 and 4/10/26, to help prevent pressure ulcers. This failure could place residents at risk for developing a pressure ulcer or worsening of a pressure ulcer, which could cause pain and infection. Findings include: Record review of Resident #2's undated face sheet revealed he was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses of severe sepsis (infection throughout body) with septic shock (organs stop working), osteomyelitis (infection of bone), urinary tract infection, stage 4 pressure ulcer of sacrum (muscle and bone visible to tailbone), COPD (lung disease), type 2 diabetes mellitus (high blood sugar), acute and chronic respiratory failure (not enough oxygen), afib (irregular heart beat), chronic kidney disease (kidneys do not filter effectively), heart failure (heart does not pump effectively), stage 3 pressure ulcer of left ankle (fat visible), unstageable pressure ulcer of right heel (scab or dead tissue covering), unstageable pressure ulcer of left heel, non-pressure (from issues with blood flow) ulcer of right foot with bone involvement, non-pressure ulcer of left lower leg, colostomy (opening to the outside with pouch to collect stool), and gastrostomy (tube into stomach for nutrition). Record review of Resident #2's MDS admission assessment dated [DATE] revealed a BIMS score of 13 out of 15 which indicated normal cognition. The resident had an impairment on one side of both the upper and lower extremities and used a wheelchair for mobility. Resident #2 was substantial/max assistance (helper does more than half the effort) for ADLs. Resident #2 had one Stage 3 (full thickness tissue loss with fat visible) pressure ulcer, two Stage 4 (full thickness tissue loss with exposed bone, tendon, or muscle) pressure ulcers, four unstageable pressure ulcers, three venous/arterial (caused by decreased blood flow) ulcers, and an infection to his foot. Resident #3 was receiving pressure ulcer/injury care, surgical wound care, application of nonsurgical dressings, application of dressings to feet, and had a pressure reducing device for his bed. Record review of Resident #2's Care Plan dated 2/19/26 revealed a focus of Pressure Injury: Resident #2 had multiple pressure injuries and was at risk for further skin break down, infection, worsening of existing pressure injury, new pressure injury formation. Unstageable to R heel. Unstageable to L heel. Stage 3 to L foot. Unstageable to L ankle. Stage 4 to L buttock. Stage 4 to sacral. Unstageable to R buttock. The goal was to have the pressure injuries show signs and symptoms of improvement through the review date. The interventions included consulting wound care, using pillows and/or positioning devices for resident positioning and comfort, providing ordered diet/feedings/supplements and encouraging intake to promote wound healing, and assisting with turning/re-positioning during rounds and PRN. Record review of Resident #2's previous hospital's wound care notes from 1/24/26 at 7:45pm revealed wound care was consulted for extensive stage 4 pressure ulcers to both ischium (buttocks), sacrum, and unstageable pressure ulcers to feet/ankles. The consult indicated Resident #2 had labs done that revealed he was malnourished and recommended supplements. Record review of Resident #2's Braden Scale from 3/11/26 at 1:40pm revealed he was high risk for developing pressure ulcers. Record review of Resident #2's Mini Nutritional Assessment from 4/6/26 at 2:26pm revealed the resident was malnourished. Record review of Resident #2's April 2026 Physician Orders revealed the following orders from MD J: Referral to Dr. [name] wound care team for an assessment, evaluation, and treatment of care. Ordered on 2/20/26.Low air loss mattress, every shift. Ordered on 2/20/26.Heel protectors to bilateral feet, every shift. Ordered on 2/20/26.Proteinex Oral Liquid, 30ml (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	via PEG BID for wound healing. Ordered on 3/13/26. Record review of Resident #2's Wound Care Note dated 4/6/26 at 2:19pm from NP S revealed he had a L buttock pressure ulcer that was 25cm x 14cm x 2.5cm with an area of 350cm. He also had a sacral pressure ulcer that was 9.5cm x 15cm x 1cm with an area of 142.5cm. Resident #2 also had a R buttock pressure ulcer that was 8.5cm x 10cm x 1cm with an area of 85cm. The wounds had been unchanged from the previous week. In an observation and interview on 4/9/26 at 10:40am, Resident #2 was observed to by lying on his back in bed. He had a sacrum pressure ulcer that was the size of a small dinner plate that connected to a L thigh pressure ulcer that was the size of two softballs next to each other. Resident #2 said he tried to stay on his side as much as possible but he always ended up on his back. There were no extra pillows or wedges observed in his room. In an interview and observation on 4/9/26 at 11:00am, RN O said Resident #2 was supposed to have a wedge for positioning. There was a wedge pillow observed on Resident #2's roommate's bed. Once wound care was finished, the resident was left on his back. In an observation on 4/9/26 at 3:50pm, Resident #2 was lying on his back in bed with no pillows or wedges. In an observation on 4/10/26 at 8:40am, Resident #2 was asleep on his back in bed with no pillows or wedges. In an observation on 4/10/26 at 9:19am, Resident #2 was asleep on his back in bed with no pillows or wedges. In an interview on 4/10/26 at 11:00am, NP S said Resident #2's wounds were not changing. She said they were not getting worse, but they were not getting better either. She said turning/repositioning would help some, but his wounds were so bad and he had so many other co-morbidities she did not know how much it would help. She said the turning/repositioning was not keeping his wounds from healing. NP S said the wounds were worse when he was first admitted and now they have plateaued. In an observation on 4/10/26 at 12:09pm, Resident #2 was asleep on his back in bed with no pillows or wedges. Record review of Resident #2's Turning and Repositioning Task as of 4/10/26 revealed the following: 4/9/26: No documentation of the resident being turned all day.4/10/26: Resident was turned at 1:14am and 9:56am. In an interview on 4/10/26 at 2:09pm, the ADM said the wedge that was on Resident #2's roommate's bed, was Resident #2's. She said it must have accidentally got put on the roommate's bed. 2. Record review of Resident #1's undated face sheet revealed she was an [AGE] year old female who admitted to the facility on [DATE] with diagnosis of need for assistance with personal care. Record review of Resident #1's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 11 out of 15 which indicated moderately impaired cognition. The resident was dependent for all ADLs and was frequently incontinent of bowel and bladder. Resident #1 had a PEG tube for nutrition and was at risk for pressure ulcers. At the time of the assessment the resident had no unhealed pressure ulcers, venous/arterial ulcers, or other wounds/skin problems. The resident had a tracheostomy (hole in neck to secure an airway) and was taking diuretics (medications to increase urination). Record review of Resident #1's Care Plan dated 10/1/25 revealed a focus of Risk for Pressure Wounds: Resident #1 was at risk for alteration in skin integrity and pressure ulcer formation AEB decline in physical/cognition function. The goal was for the resident to be free from any alterations in skin integrity over the next 90 days. Interventions included assisting with turning/repositioning during rounds and PRN and providing pressure reducing device for bed and wheel chair. Record review of Resident #1's Mini Nutritional Assessment from 3/9/26 at 12:39pm revealed the resident was malnourished. Record review of Resident #1's Braden Scale (measures risk of developing pressure ulcers) from 3/21/26 at 8:25am revealed the resident had a mild risk of developing pressure ulcers. Record review of Resident #1's Skin Observation from 3/30/26 at 9:35pm revealed she had developed redness to her sacrum. Record review of Resident #1's Skin Observation from 4/6/26 at 10:50am revealed she had developed redness to her sacrum. In an observation on 4/9/26 at 11:50am, Resident #1 was sitting up in bed eating lunch. In an observation on 4/9/26 at 3:50pm, Resident #1 was asleep on her back in bed. In an observation on 4/10/26 at 8:39am, Resident #1 was asleep in bed on her back. In an observation on 4/10/26 at 9:19am, Resident #1 was asleep in bed on her back. In an observation and interview on 4/10/26 at 12:08pm, Resident #1 was sitting up in bed. She said she never got turned from side to side. There (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were no extra pillows or wedges observed in her room. Record review of Resident #1's Turning and Repositioning Task from 4/10/26 revealed the following: 4/9/26: She was turned at 8:27pm4/10/26: She was turned at 1:08am and 9:48am 3. Record review of Resident #3's undated face sheet revealed she was a [AGE] year old female who admitted to the facility on [DATE] with diagnoses of spinal stenosis of lumbar region (narrowing of the spinal canal in the lower back), extrapyramidal and movement disorder (uncontrolled movements), and need for assistance with personal care, severe obesity. Record review of Resident #3's Quarterly MDS assessment dated [DATE] revealed a BIMS score of 15 out of 15, which indicated normal cognition. The resident was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting and required a Hoyer lift to get out of bed to wheelchair. Resident #3 was always incontinent of bowel and bladder. The assessment indicated she was at risk of developing pressure ulcers. Record review of Resident #3's Care Plan dated 9/26/25 revealed a focus of Risk for Pressure Wounds: Resident #3 was at risk for alteration in skin integrity and pressure ulcer formation. The goal was to be free from alteration in skin integrity/formation of pressure wounds over 90 days. Interventions included assisting with turning/repositioning during rounds and PRN and using padding between areas of pressure and positioning devices for proper body alignment. Record review of Resident #3's Braden Scale from 3/8/26 at 2:26pm revealed she was mild risk for developing pressure ulcers. Record review of Resident #3's Skin/Wound Note from 3/25/26 at 10:36pm revealed she had open skin on the back of her left and right thighs that had re-opened from old wounds. In an interview and observation on 4/9/26 at 9:58am, Resident #3 was on her back in bed. Resident #3 said the staff never come in to turn/reposition her. In an interview and observation on 4/9/26 at 12:00pm, Resident #3 was on her back in bed. She said no one had turned her and she was normally out of bed by then and in her wheelchair. In an observation on 4/10/26 at 8:41am, Resident #3 was asleep in bed on her back. In an interview and observation on 4/10/26 at 9:15am, Resident #3 was lying on her back in bed. She said she had not been turned/repositioned. In an observation and interview on 4/10/26 at 10:32am, Resident #3 was lying on her back in bed. She said she had not been turned/repositioned. In an observation and interview on 4/10/26 at 12:10pm, Resident #3 was sitting up in bed eating lunch. She said no one had turned her/repositioned her. Record review of Resident #3's Turning and Repositioning Task from 4/10/26 revealed the following: 4/9/26: She was turned at 1:42am and 5:51pm4/10/26: It was documented that she could turn herself at 1:06am In an interview on 4/9/26 at 9:53am, LVN J said they turn/reposition residents every 2hr. She said she and the CNA or the respiratory therapist would turn the resident. LVN J said she oversaw the turning/repositioning to ensure it was done. She said they turned residents from their back, to facing the window, to facing the door. In an interview on 4/9/26 at 10:20am, RN O said the staff were not 100% at turning/repositioning the residents. She said she was not sure if the lack of turning/repositioning was affecting the residents because she was only PRN. In an interview on 4/10/26 at 2:09pm, the ADM said she knew her staff were turning/repositioning residents but thought they were not documenting it. She said if residents were not turned/repositioned it could cause skin break down. Record review of the facility's policy and procedure on Turning and Repositioning (revised 6/2019) read in part: It is the policy of this facility that all residents identified at risk for skin breakdown will be placed on a turning/repositioning program. The turning/repositioning programs should be individualized to the resident. It should be organized, planned, documented, monitored, and evaluated based on an assessment of the resident's needs. The expected repositioning times and positions should be defined by the facility team to ensure that the care providers have a clear understanding of the resident's individualized turning/repositioning program. Completion of turning/repositioning should be documented. by the CNA or licensed nurse. Documentation should be performed in [EMR].

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 1 out of 8 residents (Resident #2) reviewed for infection control. The following occurred on 4/9/26 during wound care to Resident #2: RN O failed to wash/sanitize her hands after changing gloves.RN O failed to change gloves after wound care was finished between each wound.RN O failed to clean the wounds with one gauze at a time and used the gauze more than once.RN O failed to change her gloves after cleaning the wound and prior to putting clean treatment on the wound.RN O failed to use a new piece of honey fiber (wound care medication) when a piece fell off the resident's wound on to his brief, and she picked it back up and re-used it.RN O failed to remove her dirty gloves after wound care and proceeded to touch his clean sheets.RN O failed to keep the Santyl (wound care medication) tube from becoming contaminated by putting the tip of the medication tube directly on the same tongue depressor repeatedly after each application. These failures could place residents at risk of exposure and/or possible transmission of communicable diseases and infections, and cross contamination of wounds. The findings included: Record review of Resident #2's undated face sheet revealed he was a [AGE] year old male who admitted to the facility on [DATE] with diagnoses of severe sepsis (infection throughout body) with septic shock (organs stop working), osteomyelitis (infection of bone), urinary tract infection, stage 4 pressure ulcer of sacrum (muscle and bone visible to tailbone), COPD (lung disease), type 2 diabetes mellitus (high blood sugar), stage 3 pressure ulcer of left ankle (fat visible), unstageable pressure ulcer of right heel (scab or dead tissue covering), unstageable pressure ulcer of left heel, non-pressure (from issues with blood flow) ulcer of right foot with bone involvement, non-pressure ulcer of left lower leg, colostomy (opening to the outside with pouch to collect stool), and gastrostomy (tube into stomach for nutrition). Record review of Resident #2's MDS admission assessment dated [DATE] revealed a BIMS score of 13 out of 15 which indicated normal cognition. The resident had an impairment on one side of both the upper and lower extremities and used a wheelchair for mobility. Resident #2 was substantial/max assistance (helper does more than half the effort) for ADLs. The assessment indicated the resident had an indwelling catheter (tube into bladder to drain urine) and a colostomy. The resident was receiving nutrition through a PEG tube (tube into stomach for nutrition). According to the assessment, Resident #2 had one Stage 3 (tissue loss with fat visible) pressure ulcer, two Stage 4 (tissue loss with exposed bone, tendon, or muscle) pressure ulcers, four unstageable pressure ulcers, three venous/arterial (caused by decreased blood flow) ulcers, and an infection to his foot. Resident #3 was receiving pressure ulcer/injury care, surgical wound care, application of nonsurgical dressings, application of dressings to feet, and had a pressure reducing device for his bed. Record review of Resident #2's Care Plan dated 2/19/26 revealed a focus of Pressure Injury: Resident #2 had multiple pressure injuries and was at risk for further skin break down, infection, worsening of existing pressure injury, new pressure injury formation. Unstageable to R heel. Unstageable to L heel. Stage 3 to L foot. Unstageable to L ankle. Stage 4 to L buttock. Stage 4 to sacral. Unstageable to R buttock. The goal was to have the pressure injuries show signs and symptoms of improvement through the review date. The interventions included consulting wound care and performing treatments per order. Record review of Resident #2's April 2026 Physician Orders revealed the following orders from MD J: Left heel - Cleanse with normal saline and pat dry. Apply betadine and cover with a border dressing daily and PRN. Every day shift from 6am to 2pm, and as needed. Ordered 2/20/26 at 8:22am.Right lateral foot - Cleanse with normal saline and pat dry. Apply betadine and leave open to air daily and PRN. Every day shift from 6am to 2pm, and as needed. Ordered on 2/20/26 at2:18pm.Right heel - Cleanse with normal saline and pat dry. Apply calcium alginate (wound care medication) to open area. Apply betadine to necrotic area and (continued on next page)

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	455714	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Paradigm Northwest	17600 Cali Dr Houston, TX 77090

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infecting the wounds. She said when the nurse was cleaning the wound it would be cleaned with one gauze at a time and then thrown away, due to infection control. The DON said Resident #2 did have a lot of wounds, but no other residents had that many wounds and RN O needed to follow infection control practices for every resident. Record review of the facility's policy and procedure on Wound Evaluation (revised: 6/2019) read in part: It is the policy of this facility to evaluate wounds during dressing changes. Evaluation should be performed on admission, weekly and on discovery. Evaluation is the process in which wound characteristics, underlying conditions and contributory medical history are identified and documented. Evaluation should result in treatment approaches including intervention for causative factors and a prognosis for healing. Evaluation is the ongoing process of gathering data that becomes the basis of measurement of wound progress. With each dressing change the clinician should observe and document the following: General appearance. Drainage. Surrounding skin. Wound odor. Record review of the facility's policy and procedure on Infection Control Program (revised: 6/2024) read in part: The Facility will establish a comprehensive infection control program encompassing essential elements to safeguard the health and safety of residents, staff, and visitors. The Facility is dedicated to maintaining a safe and healthy environment by implementing an effective infection control program that adheres to state and federal regulations and follows evidence-based practices recommended by the CDC. The program's objectives encompass key infection control ideologies: prevention, identification, reporting, investigation, and control of infections and communicable diseases among residents, employees, and visitors. The Facility promotes awareness and adherence to infection control practices through the Infection Control Committee.The Infection Control Committee is tasked with ensuring compliance with policies and procedures, reviewing data and trends related to infections, conducting training and education sessions, performing audits to assess adherence to standards, and continuously monitoring and evaluating the effectiveness of infection control measures.The committee plays a pivotal role in promoting a safe and healthy environment for residents, staff, and visitors by overseeing all aspects of infection prevention and control within the facility.The Infection Preventionist will provide initial and ongoing infection control training for all staff, including competency assessments where indicated. The Infection Preventionist will use evidence-based practices to educate all staff members within their respective departments.